Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Pamela Johnson

Respondent Name
American Zurich Insurance Co

MFDR Tracking Number
M4-14-1346-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
January 14, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This charges submitted on 8-9-13 included CPT code 99213 and 99080. Both codes allow for more than $0.00 reimbursement on the fee schedule."

Amount in Dispute: $180.10

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2013	99213, 99080-73	$180.10	$133.65

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets out reimbursement guidelines for work status reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1 – Workers' compensation jurisdictional fee schedule adjustment

Issues

1. Did the respondent pay in accordance with Division guidelines?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §134.203 (c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is(date of service annual conversion factor)." The disputed services Maximum Allowable Reimbursement (MAR) will be calculated as follows;
    - Procedure code 99213, service date August 9, 2013, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.97 multiplied by the geographic practice cost index (GPCI) for work of 1.009 is 0.97873. The practice expense (PE) RVU of 1.1 multiplied by the PE GPCI of 1.002 is 1.1022. The malpractice RVU of 0.07 multiplied by the malpractice GPCI of 0.923 is 0.06461. The sum of 2.14554 is multiplied by the Division conversion factor of $55.30 for a MAR of $118.65.

    The carrier's adjustment code of W1 – "Workers' Compensation jurisdictional fee schedule adjustment" is not supported.
2. 28 Texas Administrative Code §129.5(i) states in pertinent part, "Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section… The amount of reimbursement shall be $15. (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section;" The provider billed the correct code and modifier. A payment of $15.00 is supported.
3. The total allowable reimbursement for the services in dispute is $133.65. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $133.65. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $133.65.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $133.65 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 1, 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.